MINUTES
473rd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

December 8, 2010

Chairman Frederick W. Pudderster called the meeting to order at 10:07 a.m. Commissioners George H. Bone, M.D., C. James Lowthers, Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF NOVEMBER 3, 2010

The Commission voted unanimously to approve the minutes of the November 3, 2010 Public Session.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commission on the progress of current major initiatives and issues. The major items included: 1) final FY 2011 rate orders have been completed and promulgated; 2) the limiting of the annual discussion of the Reasonableness of Charges (ROC) methodology to technical issues such as the revised Capital Policy; 3) the draft of the Maryland Hospital Preventable Re-admissions initiative will be discussed again at today's meeting; 4) staff continues to work on an evaluation structure for the Community Benefit Report; and 6) input sessions with stakeholders continue, and the draft Admission-Readmission Revenue (AAR) will be presented today.

ITEM III
DOCKET STATUS CASES CLOSED

2090N- Memorial Hospital at Easton

2095A – Johns Hopkins Health System

ITEM IV
DOCKET STATUS CASES OPEN

There were no cases presented for Commission action.

30 Day Extensions:

Staff requested that the Commission approve 30 day extensions of the time for review of

proceedings 2096N-Maryland General Hospital and 2097N-Laurel Regional Medical Center.

The Commission voted unanimously to approve staff's request.

DESCRIPTION OF THE TOTAL PATIENT REVENUE (TPR) RATE SETTING PROGRAM

Mr. Murray provided an overview of the TPR rate setting program. Mr. Murray described the TPR program as a voluntary global budget rate setting program, applicable to isolated hospitals with contained catchment areas, which assures hospitals a prescribed amount of revenue independent of the number of patients treated. Although in the past there have been as many as four hospitals on the TPR program at one time, there are currently only two, Garret County Memorial Hospital and Edward W. McCready Memorial Hospital. Initiated in 1981, the TPR program provides hospitals with very strong incentives to reduce unnecessary utilization.

Utilizing the authority granted by the Commission to negotiate individual agreements based on an approved policy framework and template, the TPR program has proven to be a very favorable mechanism to control costs and to provide hospitals with financial sustainability. In addition, the TPR program allows hospitals to serve their communities more effectively; to monitor changes in their delivery system; and to modify their agreements if necessary, while serving as a platform for the possible development of a regional Accountable Care Organization.

According to Mr. Murray, staff is negotiating with nine hospitals, with total gross patient revenue of $1.3 billion, that are interested in participating in the TPR program.

Commissioner Sexton and Chairman Pudderster asked Mr. Murray to provide a projection of how the hospitals under the TPR program will perform, so that the Commission will be able to measure the results of the program.

ITEM V
DRAFT RECOMMENDATION ON POTENTIALLY PREVENTABLE READMISSIONS METHODOLOGY

Diane Feeney, Associate Director-Quality Initiative, stated that the only change in the draft recommendation was to move the implementation date of the Potentially Preventable Readmissions (PPR) initiative from January 1, 2011 to April 1, 2011, in recognition of data issues. Ms. Feeney reported that since the last public meeting, there have been two technical/finance workgroup meetings, as well as a meeting with MHA's Quality Council to discuss the STAAR (State Action on Avoidable Re-hospitalizations) initiative infrastructure. Staff continues to work diligently on the issue of identifying readmitted patients in the short term with an algorithm and, in the long term, by developing a unique patient identifier.

Chairman Pudderster noted that the recommendation listed a number of reasons that

readmissions could reasonably be prevented by hospitals or physicians; however, the issue of patient non-compliance was omitted.

According to Mr. Murray, the PPR system is a methodology based on averages, the methodology treats patient non-compliance as a random event that all hospitals encounter. Mr. Murray noted that the methodology does adjust for mental health and substance abuse patients who tend to be more of a non-compliance problem.

Commissioner Bone expressed concern that the recommendation did not address the lack of primary care physicians in Maryland who are a key factor in coordinating care to prevent unnecessary readmissions.

Ms. Feeney stated that the STAAR Initiative, contained within the recommendation's appendix addresses the physician shortage problem by establishing cross-continuum teams that include physicians.

Commissioner Bone pointed out that that the STAAR initiative assumes that physicians are available, but they are not.

The Chairman asked Ms. Feeney how confident she was that staff could overcome patient identification problems inherent in the inter-hospital methodology.

Ms. Feeney stated that the use of the inter-hospital methodology is contingent on how well the work on the patient matching algorithm goes, and how confident staff is with its accuracy. Although we are hopeful, we don't know the answer yet. Ms. Feeney noted that staff planned to implement the PPR program with both inter and intra-hospital methodologies as long as they were satisfied that the patient matching algorithm was accurate enough. Ms. Feeney stated that staff would report back to the Commission on its progress with the algorithm.

According to Mr. Murray, the literature from experts in this area indicates that it is important to be able to at least track both inter and intra-hospital readmissions. That is why staff's emphasis has been on being in a position to track all patients. Staff believes it can successfully work through the patient identification issues; it will come to the Commission at the February public meeting with a recommendation as to whether to proceed with both inter and intra-hospital re-admissions or to delay implementation pending improvement in our ability to match patients. Mr. Murray pointed out that the PPR methodology is linked to a set of incentives that scales a very modest amount of revenue; delaying its implementation would not be a major setback.

A panel consisting of Beverly Miller, Senior Vice President-Professional Activities of the Maryland Hospital Association (MHA), Traci LaValle, Assistant Vice President-Financial Policy of the MHA, and Patrick Redman, PhD, consultant, representing the Maryland Hospital Association presented written comments on staff's proposed PPR methodology and suggested an alternative methodology.

Ms. LaValle stated that MHA supports an episodic admission-readmission bundling approach for

all hospitals. While similar to staff's proposed Admission-Readmission Revenue (ARR) arrangements, it would utilize only intra-hospital re-admission data. It would permit hospitals to voluntarily be at risk for 100% of all additional re-admissions; however, it would require all other hospitals to be at risk for 60% of all additional re-admissions. The 60% model would replace PPR scaling with hospitals that choose the 100% model being exempt from the 60% model. In essence, hospitals in the 60% model will have a fixed cost percentage of 60% and a variable cost percentage of 40%, i.e., if a hospital reduces its total re-admissions, it gets to keep 60% of the revenue associated with the reduced re-admissions; however, if total re-admissions increase, the hospital loses 60% of the revenue associated with the additional re-admissions.

Dr. Redman outlined the potential savings at the end of three years based on the experience of programs that are similar to MHA's proposal. According to Dr. Redman such programs have reduced preventable re-admissions by up to 25%. They have also produced cost savings to hospitals of 0.2% of inpatient revenue, and 0.5% savings to payers. This is based on an annual investment in transitional care coordination of 0.44%. In addition to the reduction in hospital costs, the better transition of care will lead to better outcomes.

Ms. LaValle stated that reducing re-admissions is the first step on the road towards where we think the health care delivery system is going. However, achieving savings beyond this initial model will require the development of medical home and chronic care models which will take more time, perhaps up to five or ten years and will require intense investment in care coordination, IT infrastructure, and other resources.

Ms. Miller stated that MHA wanted to continue to work with staff to develop a concept and approach for infrastructure for quality improvement, based on the STAAR initiative model, which will be most effective for reducing re-admissions in Maryland.

Hal Cohen, PhD, representing CareFirst of Maryland and Kaiser Permanente, noted that MHA's proposal included a greater fixed cost percentage, which the payers have been advocating for years. Dr. Cohen expressed support for expanding the number of hospitals on the TPR system, as well as the PPR and ARR initiatives. According to Dr. Cohen, the TPR provides the strongest incentives for savings followed by the ARR and PPR in descending order. Dr. Cohen urged the Commission to structure the incentives to hospitals to reflect their relative importance in order to encourage hospitals to participate in the most effective initiatives.

With regard to the PPR, Dr. Cohen stated that his clients support rewards based on improvement in the combination of intra-hospital and inter-hospital re-admissions. However, comparing hospitals on improvement in inter-hospital re-admissions may be difficult. When we are in a position to make that measurement, his clients would support using proven savings to fund the upfront money for the ARR infrastructure. In addition, Dr. Cohen noted that CareFirst and Kaiser recommended this year during the review of the ROC methodology that the Commission evaluate ways of changing how Indirect Medical Education is financed to encourage the training of primary care physicians.

ITEM VI
DRAFT APPROVAL AND EVALUATION TEMPLATE FOR ADMISSION-READMISSION REVENUE (ARR) ARRANGEMENTS

Mr. Murray summarized staff's draft Approval and Evaluation Template for Admission-Readmission Revenue Arrangements (see draft recommendation, "Template for Review and Negotiation of an Admission Readmission Revenue (ARR) Hospital Payment Constraint Program" on the HSCRC website).

The draft recommendations include: 1) that the basic policy framework to be utilized as the core template for negotiating ARR arrangements; 2) that the proposed agreement provide the basic template for the agreement between the Commission and any hospital entering into an ARR arrangement; and 3) that the Commission direct staff to report back to the Commission in public session on any ARR arrangements negotiated with individual hospitals.

Commissioner Sexton asked Mr. Murray how he proposed the Commission should proceed with this initiative considering the issues of: equity and the voluntary nature of ARR initiative; whether the initiative is moving the Commission to a point where success is judged not by controlling hospital rates, but by controlling total spending on hospital services; as well as the initiative's effect on the Medicare waiver.

Mr. Murray stated that based on the successful history of the Guaranteed Inpatient Revenue system which was also voluntary, staff is convinced that the ARR initiative will produce positive results. Mr. Murray acknowledged the problem of fairness in that the system that would provide the greatest rewards to hospitals that have not done a good job and not made investments to improve.

Mr. Murray observed that while we want all of these new programs to be consistent with the overall goal of bending the cost curve and payment and delivery system reform, we must also realize that this is a very complicated goal. However, if we take incremental steps, such as the ARR initiative, and modify them when necessary, we will eventually achieve our goal.

With regard to the Medicare waiver, Mr. Murray observed that although reducing re-admissions will hurt us on the waiver test, the people at The Centers for Medicare and Medicaid Services (CMS) understand and support what we are doing and are willing to work with us.

Chairman Puddester asked how much flexibility staff needed to negotiate these arrangements.

Mr. Murray stated that there is a trade-off. If the criteria are too rigid, there will be less interest from the hospitals. But more hospitals will show interest and will be more willing to present their individual cases if staff has some degree of flexibility. However, it is the Commission's decision on how much flexibility they grant to staff.

Barry Rosen, representing United Healthcare, expressed concern that under both the ARR initiative and MHA's proposal hospitals would get to keep the upfront funding even they do nothing and their re-admissions remain the same. Mr. Rosen asserted that what is missing from the ARR initiative and MHA's proposal is a guarantee like the one made by MHA, in the joint proposal by CareFirst, United Healthcare, Medicaid, and MHA to settle the 2010 Update Factor, that re-admissions will be reduced.

Mr. Rosen suggested that of the two proposals the ARR initiative would be more effective in reducing readmissions and therefore, more appropriate for upfront funding.

Dr. Cohen expressed support for the 100% reward for reducing re-admissions in the ARR initiative if it is coupled with low update factors. Dr. Cohen urged that upfront costs should be included in the update factor slippage adjustment and that they be paid back.

ITEM VII
UPDATE ON STATUS OF A STATE-ONLY PHYSICIAN LOAN ASSISTANCE REPAYMENT PROGRAM

Steve Ports, Principal Deputy Director-Policy and Operations, summarized the background and current status of the proposed State-Only Loan Assistance Repayment Program (LARP). Mr. Ports reported that there is currently a federal LARP within the Maryland Higher Education Commission (MHEC), which provides funding to provide primary care physicians to pay their education loans, in exchange for a commitment to practice in an area of the State where there is a physician shortage. However, most jurisdictions in Maryland do not qualify for the Program because the federal definition of "areas with a physician shortage" is so restrictive.

As a result, the Task Force on Health Care Access and Reimbursement recommended that a State-Only LARP funded through hospital rates be created. However, the Task Force stipulated that the State-Only program should only be created if: 1) it is in the public interest; 2) it is consistent with the Medicare waiver; and 3) it does not significantly increase costs to Medicare, which would place the Medicare waiver in jeopardy. Legislation was adopted in 2009 to permit MHEC to utilize funding from the HSCRC provided through hospital rates for the State-Only LARP program.

Subsequently, the Secretary of Health directed the HSCRC to work with MedChi to draft a letter for his signature, directed to the Center for Medicare and Medicaid Services (CMS) Administrator describing the value of a State-Only LARP program in Maryland and to request a meeting with the objective of gaining CMS approval. The letter went out several months ago, but as of this date, the Secretary has not received a reply.

VIII
LEGAL REPORT

Regulations

Final Adoption

Uniform Accounting and Reporting System for Hospitals and Related Organizations – COMAR 10.37.01.03L-1

The purpose of this action is to require hospitals to file with the Commission an Annual Debt Collection Report in the form prescribed by the Commission.

The Commission voted unanimously to approve the final adoption of this amended regulation.

SPECIAL PRESENTATION
TO FORMER HSCRC CHAIRMAN, DONALD A. YOUNG, M.D.

Mr. Murray presented Donald A. Young, M.D. with a plaque honoring him for his service to the citizens of Maryland as Chairman of the Health Services Cost Review Commission. Mr. Murray praised Dr. Young for his vision in recognizing the importance of constraining payment growth as a necessary element in delivering better and more affordable health care to Marylanders and the internal composition to remain true to his policy beliefs. Mr. Murray stated that Dr. Young was not only an eloquent spokesperson on behalf of the Commission and the public interest, but he was also a respectful and fair-mined listener – committed to hearing all sides of an issue.

From his perspective as Executive Director, Mr. Murray observed that Dr. Young always sought to protect staff by standing with them on the front lines. He provided guidance and direction, never failed to consider all-sides of an issue carefully, and did so with class and dignity. During his tenure, Dr. Young clearly lived up to his billing as a Scholar and Gentleman.

ITEM X
HEARING AND MEETING SCHEDULE

January 12, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
February 2, 2011	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 12:07 p.m.